

Bob Marcantonio
Consultant, Health and
Welfare &
Ed Doherty
Compliance Consultant,
Health and Welfare,
Cammack LaRhette
Consulting

Benefits in the 2012 Plan Year

What are your New Year Resolutions?

As individuals we may make voluntary resolutions to change some aspect of our lives for the new year. As benefit professionals, we face changes in 2012—some voluntary, some not. This article seeks to address some of the changes coming in 2012, both voluntary and involuntary, and what you may have resolved to do.

W-2 Reporting for the 2012 Tax Year

The 2012 tax year will mark the first year of mandatory reporting of the value of coverage under an employer-sponsored group health plan. This was set to take affect for the 2011 tax year, but the Internal Revenue Service (IRS) delayed this until 2012 specifically to allow employers more time to adapt to the system. 2012 has arrived and there likely will be no additional delay, so most plan sponsors should look to their payroll vendors to ensure the processes are in place to meet this requirement.

Employers are required to report the total cost of all medical coverage under a group health plan that the employer makes available to the employee that is non-taxable to the employee. For the most part, this excludes dental or vision coverage under a separate policy or plan, ancillary benefits like life insurance, AD&D and disability, workers compensation, work site benefits where the employee pays the premiums on an after-tax basis, and employee contributions to Archer MSAs, HSAs and FSAs.

Multiemployer plans, Health Reimbursement Arrangements, dental and vision plans that are not integrated into another group health plan, and self-insured plans of employers not subject to COBRA continuation coverage or similar requirements are exempt from this reporting. Also, employers do not need to report the value of medical coverage when furnishing Forms W-2 to employees who terminate before the end of a calendar year and request their Form W-2 before the end of that year.

Employers filing fewer than 250 Forms W-2 will not be required to report the value of coverage until such time as the IRS publishes guidance. At least six months of advanced notice will be given to provide transitional relief to those employers. It is not known if the IRS will ever require these smaller employers to file. For more information go to:

http://www.clcinc.com/pdfs/How_to_Highlight_the_Value_of_Health_Insurance_on_the_Form_W-2.pdf



The SBC, SPD, and Plan Documents

On August 22, the Department of Health and Human Services (HHS) released a Notice of Proposed Rulemaking for Summaries of Benefits and Coverage (SBCs) under the Patient Protection and Affordable Care Act (Affordable Care Act). The proposed rule provides guidance on the information that must be provided to all individuals enrolling in a medical plan on or after March 23, 2012. SBCs will include:

- A four page (double-sided) Benefit Summary
- Medical Scenarios called “Coverage Examples” that are patterned after the Food and Drug Administration food labels. They estimate customer costs based on the specific plan’s benefits for three medical scenarios – Maternity, Breast Cancer Treatment and Managing Diabetes
- A Uniform Glossary of medical and insurance terms
- A phone number and website where individuals can get additional information including documents such as Certificates, Summary Plan Descriptions (SPDs) and policies

HHS requested that the National Association of Insurance Commissioners develop the template. An example of the document can be found here: http://www.naic.org/documents/committees_b_consumer_information_hhs_dol_submission_1107_soc_populated.pdf

HHS received numerous public comments and while not specifically delaying the effective date, the DOL said “it is anticipated that the Departments’ final regulations, once issued, will include an applicability date that gives group health plans and health insurance issuers sufficient time to comply.”

It should be noted that the SBC does not replace or modify ERISA’s Summary Plan Description (SPD) requirement or contents therein. Benefit managers should take time to examine their SPD and ensure it is fully compliant and updated. Note that time and again, case law has supported the notion of the SPD being the primary vehicle for informing individuals about the plan and where there have been conflicts between it and another plan document or even an insurance policy, courts tend to interpret the ambiguity against the plan sponsor. This includes eligibility, benefit levels, coverage and limitations and cost among other plan provisions.

Creditable Coverage Disclosures to CMS

The Centers for Medicare and Medicaid (CMS), an agency of HHS, requires that most plans that currently provide prescription drug coverage to Medicare Part D eligible individuals disclose to CMS whether the coverage is “creditable



prescription drug coverage.” This disclosure must be made within 60 days after the beginning date of the Plan Year for which the entity is providing the disclosure.

CMS must be notified within 30 days of any change in status, including cancellation of the prescription drug plan. Plans file the creditable coverage disclosure to CMS online at:

https://www.cms.gov/CreditableCoverage/45_CCDisclosureForm.asp

Forms 5500

Plan sponsors generally must file a Form 5500 return on the last day of the seventh month after their plan year ends. This means that mid-year plan filings are due January 31st 2012. Plans file the Form 5500 electronically via the EFAST system at: <http://www.efast.dol.gov/welcome.html>

Plans can request a two-and-a-half month extension by filing IRS Form 5558. It is important to note that the Form 5558 must be filed before the original, un-extended due date of the Form 5500. Form 5558 is still filed on paper with the IRS directly.

Covering Women’s Preventive Services with No Cost Sharing

In early August of 2011, HHS announced new guidelines for more preventive services for women. These are in addition to the coverage of evidence-based preventive services under the Affordable Care Act like mammograms, colonoscopies, blood pressure checks, and childhood immunizations, all without charging a copayment, deductible or coinsurance. The new covered services for women’s preventive care include:

- Well-woman visits
- Screening for gestational diabetes
- Human papillomavirus (HPV) DNA testing for women 30 years and older
- Sexually-transmitted infection counseling
- Human immunodeficiency virus (HIV) screening and counseling
- FDA-approved contraception methods and contraceptive counseling
- Breastfeeding support, supplies, and counseling
- Domestic violence screening and counseling

Non-grandfathered health plans will need to include these services without cost sharing for plan years beginning on or after August 1, 2012. HHS has indicated that some religious organizations may have an additional year to comply, but the Department has yet to publish the details for qualifying for the extension.

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For more information on our healthcare practice or any of our other services please contact Frank Lonardo, Practice Leader at 1-212-227-7770 or flonardo@clcinc.com.

